Laser Wellness of Alabama Family Practice, P. C.
370 St Lukes Drive
Montgomery, AL 36117
334.213.0700

PRE TREATMENT EVALUATION

Patient Name:_____ Date:_____ DOB:_____

1. Have you ever seen a physician for your skin: Circle Yes or No If so why?_____
2. What skin care products are you currently using? Circle: cleanser, toner, moisturizer, sunscreen, skin lightener, Vitamin C, exfoliating scrubs or masks Other list:_____
3. Have you ever had any of the following? Circle: Chemical Peel, Laser Resurfacing, Dermabrasion, Microdermabrasion, Facial Surgery, Cold Sore
4. Do you have problems healing from a cut or burn: Yes or No
5. Do you wear contact lenses? Yes or No
6. Do you ever use depilatories or waxes on you face? Yes or No If so when was it last used?_____
7. What topical medications have you used on your skin in the last month?_____
8. Have you taken any oral medications to make you sun sensitive such as tetracycline or doxycycline? Yes or No
9. Have you ever taken Accutane? Yes or No If so when was it last used?_____
10. List all Medications that you are currently taking: _____

    _____
11. Are you or have you taken in the last 2 weeks coumadin, aspirin, blood thinners, motrin, advil, other NSAIDS, or steroids? If so what:_____
12. List all past surgeries and/or tissue trauma:

_____

_____
13. Are you pregnant or lactating? Yes or No
14. Do you have permanent makeup or tattoos? Yes or No If so indicate area:_____

SKIN TYPE:

15. Does your skin ever flake or feel tight and dry? Circle: Frequently, Occasionally, or Rarely
16. Is your skin ever shiny after cleansing? Circle: Frequently, Occasionally or Rarely
17. How often do you experience blackheads or blemishes? Circle: Frequently, Occasionally or Rarely
18. How noticeable are your pores? Circle: Frequently, Occasionally, or Rarely
19. Do you only experience breakouts during or around your menstrual cycle: Yes or No
20. Have you ever had a skin allergy or sensitivity?_____ If so what?_____

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LASER WELLNESS

PRE TREATMENT EVALUATION CONT'D

21. What was the cause to the above allergy:_____ or Unknown_____

22. Do you flush or appear reddened when you eat spicy food, drink alcohol, get angry or go in the sun? Yes or No

PIGMENTATION:

23. Circle what best describes your pigmentation: Even, Uneven, Birthmark, Pregnancy Mask, Freckles, Age Spots

24. Circle what best describes how you tan? I: Burns Easily; II Usually Burns; III Sometimes Burns IV Rarely Burns V Never Burns (Brown) VI Never Burns (Black)

25. What is your ethnic background?_____

VASCULARITIES:

26. Circle areas that have increased vascularities: Nose, Cheek, Chin, Forehead, Entire Face

FACIAL WRINKLES:

27. Do you have deep wrinkles, crows feet or fine lines? Yes or No If so which areas are of concern to you?_____

28. Have you ever been treated with Botox, Collagen, Fillers, Fat Transfer? Yes or No If so which ones: _____

SUN HISTORY:

29. Do you spend a lot of time outdoors? Yes or No

30. Do you ever use a tanning bed? Yes or No

31. Do you currently wear sun protection product all day, every day? Yes or No

32. Have you or any member of your family had skin cancer?_____

What is your primary concern?_____

Patient Name:_____ Date:_____

Signature:_____